

**IN THE UNITED STATES PATENT & TRADEMARK OFFICE  
BEFORE THE BOARD OF PATENT APPEALS AND INTERFERENCES**

Group Art Unit: 3626  
Examiner: Natalie Pass

Application of :	Amar et al.
Serial No. :	09/921,654
Filing Date :	August 3, 2001
Entitled :	PRACTICE MANAGEMENT AND BILLING AUTOMATION SYSTEM

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Commissioner for Patents  
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**BRIEF ON APPEAL**

Appellant submits the following Brief on Appeal in connection with the above-identified patent application. The Appellant filed a Notice of Appeal together with the \$500.00 Notice of Appeal fee on June 3, 2008. As a result, the due date for filing the Brief on Appeal is August 3, 2008. Appellant authorizes the Commissioner to charge Attorney's Deposit Account No. 50-3081 for the Appeal Brief fee (\$510.00), and any other necessary fee.

**I. REAL PARTY IN INTEREST**

The real party in interest in the above application is the assignee, athenahealth, Inc. a corporation organized and existing under the laws of the Commonwealth of Massachusetts, and having an office and place of business located at 311 Arsenal Street, Watertown, Massachusetts, 02472.

**II. RELATED APPEALS AND INTERFERENCES**

There are no other prior or pending appeals, interferences or judicial proceedings known to appellant, the Appellant's legal representative, or the assignee which may be related to, directly affect or be directly affected by, or have a bearing on the Board's decision in the pending appeal.

**III. STATUS OF CLAIMS**

Claims 1-20 were presented for examination.

Claims 21-33 were added.

Claims 7-8, 17, 21-23 and 29 were cancelled.

Claims 1-6, 9-16, 18-20, 24-28 and 30-33 stand rejected.

Claims 1-6, 9-16, 18-20, 24-28 and 30-33 are on appeal.

**IV. STATUS OF AMENDMENTS**

Appellant has not filed an Amendment Under 37 C.F.R. §1.116.

**V. SUMMARY OF THE CLAIMED SUBJECT MATTER**

Claims 1, 15, 20, 27, and 28 are the independent claims on appeal. While 37 CFR 41.37 requires reference to the specification by page and line number, the application includes paragraph numbers instead of line numbers. Therefore, Applicant's reference to the specification by page, paragraph number, and sentence number where appropriate.

**Claim 1**

Claim 1 claims a method for managing a medical practice. (See, page 1, [0002] and [0007] at sentence one). The claimed method includes eleven steps. First, in step (a) one or more insurance rules are stored in an insurance company rules database (66 in FIG. 2A) on a medical practice management server (14 in FIG. 1). (See, page 2, [0035] at sentence one through three, page 3, [0039] at sentences one through five, [0042] at sentence two, [0045] at sentences two and three, [0048] at sentences one through three). In the second step (b) of the method, a medical practice client user interface (36 in FIG. 1) is communicated with over a first communication network (26 in FIG. 1, also referred to as a "medical practice client-server network"). (See, page 1, [0035] at line two, page 3, [0036] at sentence one, [0038] at lines one through four).

In the third step (c) of the method, a payor server (18 in FIG. 1) is communicated with over a second network (34 in FIG. 1, also referred to as a "payor server network"). (See, page 1, [0007] at sentences three, four, and six; page 3, [0035] at sentences one through three, [0036] at sentence one; page 5, [0062] at sentences one through four; page

6, [0072] at sentence four). In the fourth step (d) of the method, information associated with an event related to a patient is received from at least one of the medical practice client user interface (36 in FIG. 1) or the payor server (18 in FIG. 1). (See, page 5, [0061] at sentences one and two, [0062] at sentence one). In the fifth step (e) of the method the medical practice management server (14 in FIG. 1) performs one or more workflow tasks in a patient workflow (FIGS. 3B and 3E) associated with the event. (See, page 5, [0062] at sentences two through four, [0063] at sentences one and two; page 6, [0069] at sentences one through three, [0071] at sentences two and three, [0072] at sentence three, [0074] and [0075]; page 7, [0079], [0081] at sentence two, [0082] at sentence three, [0083] at sentence one).

In the sixth step (f) of the method, the medical practice management server (14 in FIG. 1) performs one or more workflow tasks in a billing workflow (FIG. 3F), which creates, examines, and processes an insurance claim associated with the event. (See, page 5, [0063] at sentence one; page 7, [0086] – [0088]). Seventh, in step (g) the information associated with the event are automatically and repeatedly interacted with during the patient workflow tasks and billing workflow tasks to correct an error, a deficiency, or any combination thereof by applying one or more rules within a set of rules in a rules engine (60 in FIG. 2A). (See, FIG. 2B, page 3, [0042], [0045]; page 5, [0062], [0064] at sentences two through four, [0066] at sentence three, [0067] at sentences two and five; page 6, [0068], [0072] at sentence three; page 7, [0084] at sentence four).

In the eighth step (h) of the method, at least a portion of the information associated with the event, which is defined by the one or more insurance rules in the insurance company rules database (66 in FIG. 2A) that apply to the payor server (18 in FIG. 1) is used to create the insurance claim, which is formatted according to the one or more insurance rules that apply to the payor server (18 in FIG. 1), is used following completion of the one or more tasks. (See, FIG. 3A; page 3, [0045], [0048]; page 5, [0062]). Ninth, in step (i) the insurance claim is submitted to the payor server (18 in FIG. 1). (See, page 4, [0058] at sentence six).

Tenth, in step (j) the insurance claim is automatically and repeatedly interacted with to correct an error by applying a new rule, an updated rule, or both received from the payor server (18 in FIG. 1). (See, page 4, [0049] – [0050], [0052] at sentences two through four), [0057] at sentences three and four, [0059]). In the eleventh step (k) of the method, the one or more insurance rules in the insurance company rules database (66 in FIG. 2A) that apply to the payor server (18 in FIG. 1) are automatically and repeatedly updated by applying the new rule, the updated rule, or both received from the payor server (18 in FIG. 1). (See, page 4, [0050] – [0051]; page 8, [0087] at sentences three and four).

#### Claim 15

Claim 15 recites a medical practice management system (5 in FIG. 1). (See, page 1, [0002] and [0007] at sentence one; page 2, [0035] at sentence one). The medical

practice management system (5 in FIG. 1) includes a medical practice client user interface (36 in FIG. 1) for communicating with a medical practice (10 in FIG. 1). (See, page 2, [0036] at sentence one; page 3, [0038] at lines one through four). The medical practice management system (5 in FIG. 1) includes a payor server (18 in FIG. 1) for communicating with a payor organization. (See, page 2, [0035] at sentence one; page 3, [0041] at sentences five through seven).

The medical practice management system (5 in FIG. 1) includes a medical practice management server computer (14 in FIG. 1). (See, page 2, [0035] at sentence one through three; page 3, [0039] at sentences one through five). The medical practice management server computer (14 in FIG. 1) is in communication with the medical practice client user interface (36 in FIG. 1) over a first communications network (26 in FIG. 1, also referred to as a “medical practice client-server network”). (See, page 1, [0035] at line two, page 3, [0036] at sentence one, [0038] at lines one through four). The medical practice management server computer (14 in FIG. 1) is in communication with the payor server (18 in FIG. 1) over a second communications network (34 in FIG. 1, also referred to as a “payor server network”). (See, page 1, [0007] at sentences three, four, and six; page 3, [0035] at sentences one through three, [0036] at sentence one). The medical practice management server computer (14 in FIG. 1) receives information associated with an event related to a patient from at least one of the medical practice client user interface (36 in FIG. 1), the payor server (18 in FIG. 1), or any combination

thereof. (See, page 5, [0062] at sentences one through four; page 6, [0072] at sentence four).

The medical practice management server computer (14 in FIG. 1) includes an insurance company rules database (66 in FIG. 2A) storing one or more sets of rules, each set of rules comprises one or more insurance rules that apply to the payor server (18 in FIG. 1). (See, FIG. 3A; page 3, [0045], [0048]; page 5, [0062] at sentence four). The medical practice management server computer (14 in FIG. 1) includes a workflow processing engine (56 of FIG. 2A) performing one or more patient workflow tasks and one or more billing workflow tasks, which creates, examines, and processes an insurance claim, associated with the event. (See, FIGS. 8B – 8D; page 3, [0042] at line 1, [0043]). The medical practice management server computer (14 in FIG. 1) includes a rules engine (60 in FIG. 2A) in communication with the workflow processing engine (56 of FIG. 2A) for repeatedly and automatically interacting with the information associated with the event to correct an error, a deficiency, or any combination thereof by applying one or more rules in a set of rules to the information in connection with the performance of the one or more patient workflow tasks and one or more billing workflow tasks. (See, FIG. 2B, page 3, [0042], [0045]; page 5, [0062], [0064] at sentences two through four, [0066] at sentence three, [0067] at sentences two and five; page 6, [0068], [0072] at sentence three; page 7, [0084] at sentence four).

The medical practice management server computer (14 in FIG. 1) includes an intelligent transactions relationship module (68 in FIG. 2A, also referred to as “ITR”) in

communication with the workflow processing engine (56 in FIG. 2A) and the payor server (18 in FIG. 1) for submitting the insurance claim to the payor server (18 in FIG. 1). (See, page 3, [0042] at sentence one; page 4, [0058]). The intelligent transactions relationship module (68 in FIG. 2A) automatically and repeatedly interacts with the insurance claim to correct an error by applying a new rule, an updated rule, or both received from the payor server (18 in FIG. 1). (See, page 4, [0049] – [0050], [0052] at sentences two through four), [0057] at sentences three and four, [0059]). The intelligent transactions relationship module (68 in FIG. 2A) automatically and repeatedly updating one or more insurance rules in the insurance company rules database (66 in FIG. 2A) that apply to the payor server (18 in FIG. 1) by applying the new rule, the updated rule, or both received from the payor server (18 in FIG. 1). (See, page 4, [0050] – [0051]; page 8, [0087] at sentences three and four).

#### Claim 20

Claim 20 claims a medical practice management system (5 in FIG. 1). (See, page 1, [0002] and [0007] at sentence one; and page 2, [0035] at sentence one). The claimed system includes eleven means plus function elements as permitted by 35 U.S.C. §112, paragraph six. First, element (a) claims a means for storing one or more insurance rules in an insurance company rules database (66 in FIG. 2A) on the medical practice management system (14 in FIG. 1). The structure, function, or acts disclosed in the specification are the rules engine (60 in FIG. 2A), the rules database interface (64 in FIG.

1), the rules database (66 in FIG. 2A), and equivalents. (See, page 2, [0035] at sentence one through three, page 3, [0042], [0045] at sentences two and three, [0047], [0048] at sentences one through three). The second element (b) of the medical practice management system (5 in FIG. 1) recites a means for communicating with a medical practice client user interface (36 in FIG. 1) over a first communication network (26 in FIG. 1, also referred to as a “medical practice client-server network”). The structure, function, or acts disclosed in the specification are standard telephone lines, LAN or WAN links (e.g., T1, T3, 56 kb, X25), broadband connections (e.g., ISDN, Frame Relay, ATM), and wireless connections, using a variety of communication protocols (e.g., TCP/IP, IPX, SPX, NetBIOS, Ethernet, RS232, and direct asynchronous connections), and equivalents. (See, page 1, [0035] at line two, page 3, [0036], [0038] at lines one through four).

The third element (c) of the medical practice management system (5 in FIG. 1) claims a means for communicating with a payor server (18 in FIG. 1) over a second network (34 in FIG. 1, also referred to as a “payor server network”). The structure, function, or acts disclosed in the specification are standard telephone lines, LAN or WAN links (e.g., T1, T3, 56 kb, X25), broadband connections (e.g., ISDN, Frame Relay, ATM), and wireless connections, using a variety of communication protocols (e.g., TCP/IP, IPX, SPX, NetBIOS, Ethernet, RS232, and direct asynchronous connections), and equivalents. (See, page 1, [0007] at sentences three, four, and six; page 3, [0035] at sentences one through three, [0036]; page 5, [0062] at sentences one through four; page

6, [0072] at sentence four). The fourth element (d) of the medical practice management system (5 in FIG. 1) claims a means for receiving information associated with an event related to a patient from at least one of the medical practice client user interface (36 in FIG. 1) or the payor server (18 in FIG. 1). The structure, function, or acts disclosed in the specification is the medical practice management server computer (14 in FIG. 1) that is in communication with the medical practice client user interface (36 in FIG. 1) over the first communications network (26 in FIG. 1) and the payor server (18 in FIG. 1) over the second communications network (34 in FIG. 1), and equivalents. (See, page 1, [0007] at sentences three, four, and six; page 2 at [0035] at sentences one through three, [0036] at sentence one; and page 3 at [0038] at lines one through four; page 5, [0061] at sentences one and two, [0062] at sentences one through four; and page 6, [0072] at sentence four).

The fifth element (e) of the medical practice management system (5 in FIG. 1) claims a means for performing one or more workflow tasks in a patient workflow (FIGS. 3B and 3E) associated with the event. The structure, function, or acts disclosed in the specification is the workflow processing engine (56 of FIG. 2A) of the medical practice management server (14 in FIG. 1), and equivalents. (See, FIGS. 8B – 8D; page 3, [0042] at line 1, [0043]; page 5, [0062] at sentences two through four, [0063] at sentences one and two; page 6, [0069] at sentences one through three, [0071] at sentences two and three, [0072] at sentence three, [0074] and [0075]; page 7, [0079], [0081] at sentence two, [0082] at sentence three, [0083] at sentence one).

The sixth element (f) of the medical practice management system (5 in FIG. 1) claims a means for performing one or more workflow tasks in a billing workflow (FIG. 3F), which creates, examines, and processes an insurance claim associated with the event. The structure, function, or acts disclosed in the specification is the workflow processing engine (56 of FIG. 2A) of the medical practice management server (14 in FIG. 1), and equivalents. (See, page 5, [0063] at sentence one; page 7, [0086] – [0088]). The seventh element (g) of the medical practice management system (5 in FIG. 1) claims a means for automatically and repeatedly interacting with the event during the patient workflow tasks and billing workflow tasks to correct an error, a deficiency, or any combination thereof by applying one or more rules within a set of rules in a rules engine (60 in FIG. 2A). The structure, function, or acts disclosed in the specification is the rules engine (60 in FIG. 2A), or equivalents. (See, FIG. 2B, page 3, [0042], [0045]; page 5, [0062], [0064] at sentences two through four, [0066] at sentence three, [0067] at sentences two and five; page 6, [0068], [0072] at sentence three; page 7, [0084] at sentence four).

The eighth element (h) of the medical practice management system (5 in FIG. 1) claims a means for using at least a portion of the information associated with the event, which is defined by the one or more insurance rules in the insurance company rules database (66 in FIG. 2A) that apply to the payor server (18 in FIG. 1) to create the insurance claim, which is formatted according to the one or more insurance rules that apply to the payor server (18 in FIG. 1), is used following completion of the one or more tasks. The structure, function, or acts disclosed in the specification is the medical

practice management server (14 in FIG. 1), or equivalents. (See, FIG. 3A; page 3, [0045], [0048]; page 5, [0062]). The ninth element (i) of the medical practice management system (5 in FIG. 1) claims a means for submitting the insurance claim to the payor server (18 in FIG. 1). The structure, function, or acts disclosed in the specification is the ITR Module (68 of FIG. 2A), or equivalents. (See, page 4, [0058] at sentence six).

The tenth element (j) of the medical practice management system (5 in FIG. 1) claims a means for automatically and repeatedly interacting with the insurance claim to correct an error by applying a new rule, an updated rule, or both received from the payor server (18 in FIG. 1). The structure, function, or acts disclosed in the specification is the ITR Module (68 of FIG. 2A), or equivalents. (See, page 4, [0049] – [0050], [0052] at sentences two through four), [0057] at sentences three and four, [0059]). In the eleventh step (k) of the method, the one or more insurance rules in the insurance company rules database (66 in FIG. 2A) that apply to the payor server (18 in FIG. 1) are automatically and repeatedly updated by applying the new rule, the updated rule, or both received from the payor server (18 in FIG. 1). The structure, function, or acts disclosed in the specification is the ITR Module (68 of FIG. 2A), or equivalents. (See, page 4, [0050] – [0051]; page 8, [0087] at sentences three and four).

Claim 27

Claim 27 claims a method for managing a medical practice. (See, page 1, [0002] and [0007] at sentence one). The claimed method includes eleven steps (i.e., steps (a) through steps (k)), many of which include similar limitations as Claim 1. The first step (a) of the method is similar to the first step (a) of claim 1, except claim 27 recites “rules” instead of “insurance rules” and omits “on a medical practice management server” as included in step (a) of claim 1. The second and third steps (b) and (c) of the method include similar limitations as the second and third steps (b) and (c) of claim 1. The fourth step (d) of the method is similar to the fourth step (d) of claim 1, except claim 27 additionally includes “or any combination thereof” at the end of step (d). The fifth and sixth steps (e) and (f) of the method are similar to the fifth and sixth steps (e) and (f) of claim 27, except both steps omit “, by the medical practice management server,” as included in the fifth and sixth steps (e) and (f) of claim 1. The ninth, tenth, and eleventh steps (i) through (k) of the method include similar limitations to the ninth, tenth, and eleventh steps (i) through (k) of claim 1.

In the seventh step (g) of the method, after performance of the one or more workflow tasks in the patient workflow (FIGS. 3B and 3E) and the one or more workflow tasks in the billing workflow (FIG. 3F), storing at least a portion of the information associated with the event, which is defined and formatted by the one or more rules in the insurance company rules database (66 in FIG. 2A) that apply to the payor server (18 in FIG. 1), for a purpose other than to create the insurance claim. (See, page 4, [0054] - [0055]; page 7, [0074]). In the eighth step (h) of the method, the information

associated with the event in connection with the performed patient workflow and billing workflow tasks is automatically and repeatedly interacted with by applying one or more rules to correct an error, a deficiency, or any combination thereof. (See, FIG. 2B, page 3, [0042], [0045]; page 5, [0062], [0064] at sentences two through four, [0066] at sentence three, [0067] at sentences two and five; page 6, [0068], [0072] at sentence three; page 7, [0084] at sentence four).

Claim 28

Claim 28 claims a computer program product, tangibly embodied in an information carrier, for managing a medical practice management system. (See, page 1, [0002] and [0007] at sentence one). The claimed method includes eleven steps (a) through (k) that include similar limitations to steps (a) through (k) of claim 1.

**VI. GROUNDS OF REJECTION TO BE REVIEWED ON APPEAL**

The grounds of rejection on appeal are:

(1) the final rejection of claims 1, 15, 20, 27, and 28 under 35 U.S.C. §112, first paragraph as containing subject matter which was not described in the specification in such a way as to reasonably convey to one skilled in the relevant art that the inventor(s) at the time the application was filed, had possession of the claimed invention. According to the Final Office Action mailed on March 12, 2008 (hereinafter “the Final Office Action”, there is no support for “to correct an error by applying a new rule, an updated rule, or both” as disclosed in claims 1, 15, 20, 27, and 28;

(2) the final rejection of claims 1-6, 13-16, 18-20, 24-28, and 30-33 under 35 U.S.C. § 103(a) as being unpatentable over U.S. Patent Number 6,453,297 to Burks et al. (hereinafter “Burks”) and U.S. Patent Number 6,047,259 to Campbell et al. (hereinafter “Campbell”), for substantially the same reasons given in the previous Office Action (paper number 20070829), and further in view of U.S. Patent Number 5,253,164 to Holloway et. al. (hereinafter “Holloway”);

(3) the final rejection of claims 9-11 under 35 U.S.C. § 103(a) as being unpatentable over Burks and Campbell and Holloway as applied to claims 1 and 2, and further in view of U.S. Patent Number 5,995,939 to Berman et al. (hereinafter “Berman”) for substantially the same reasons given in the previous Office Action (paper number 20070829); and

(4) the final rejection of claim 12 under 35 U.S.C. § 103(a) as being unpatentable over Burks and Campbell and Holloway as applied to claims 1 and 2, and further in view of U.S. Patent Number 6,757,898 to Ilsen et al. (hereinafter “Ilsen”) for substantially the same reasons given in the previous Office Action (paper number 20070829).

**VII. ARGUMENT****A. The Rejection of Amended Claims 1, 15, 20, 27, and 28 under 35 U.S.C.****§ 112, First Paragraph**

The Final Office Action rejected independent claims 1, 15, 20, 27, and 28 as failing to comply with the written description requirement. Specifically, the Final Office Action rejected claims 1, 15, 20, 27, and 28 for containing subject matter which was not described in the specification in such a way as to reasonably convey to one skilled in the art that the inventors at the time of the application filing had possession of the claimed invention. According to the Final Office Action, the specification does not support correcting an error by applying a new rule, an updated rule, or both. Appellant disagrees and respectfully requests reversal.

The requirement of section 112, first paragraph, is satisfied when one skilled in the relevant art would understand what is intended and would know how to carry it out. See, *In re Hayes*, 25 U.S.P.Q.2d 1241, 982 F.2d 1527, 1533-1534 (Fed. Cir. 1992). Applicant is not required to describe the subject matter exactly as claimed, rather the specification needs to contain an equivalent description. See, *Lockwood v. American Airlines, Inc.*, 41 U.S.P.Q.2d 1961, 107 F.3d 1565, 1572 (Fed. Cir. 1997).

In the present application, claims 1, 15, 20, 27, and 28 recite “interacting with the insurance claim to correct an error by applying a new rule, an updated rule, or both ...”

This subject matter is supported, for example, by the following seven passages in the originally-filed specification:

“The workflow processing engine 56 is additionally in communication with the rules engine 60. The rules engine 60 enables real-time application of “rules” stored in the rules database 66.” See, ¶¶ [0045].

“To ensure that the rules database 66 contains current rules, the rules database 66 is frequently updated.” See, ¶¶ [0050].

“The medical practice management server 14 automatically and repeatedly interacts with the information associated with the event in connection with the performed tasks by applying one or more rules in a set of rules and/or by performing transactions with the payor server 18.” See, ¶¶ [0062].

“The workflow processing engine 56 transmits the claim entry form (step 389), which ultimately becomes the claim, to the rules engine 60. The rules engine 60 “scrubs” the claim (step 390), or examines the claim for claim errors. Claim errors can include, without limitation, typographical errors, formatting errors (based on a format that each payor defines for their claims), incomplete information, and the like. As described above, the payor server 18 and/or the rule specialists can update the rules database 66 with new or updated rules. Thus, the rules engine 60 can apply different rules to a claim at different times, depending on if the rules database 66 is updated or changed during the life of the claim.” See, ¶¶ [0087].

“The workflow processing engine 56 then transmits a claim review screen to the medical practice client 10 illustrating the errors in the claim. An exemplary claim review screen 756 is illustrated in FIG. 7C. In one embodiment, these errors must be resolved before the medical practice management server 14 can process the claim. Moreover, in one embodiment the workflow processing engine 56 assigns some sort of HOLD status (e.g., MGRHOLD) to

the incorrect claim to denote that the claim cannot currently be transmitted to the payor server 18.” See, FIG. 7C and ¶¶ [0089].

“The workflow processing engine 56 then determines if the claim has its claim status set to DROP (step 394). If so, the workflow processing engine 56 submits the claim to the payor (i.e., payor server 18) using the ITR module 68 (step 396).” See, ¶¶ [0091].

“The workflow processing engine 56 and/or the ITR module 68 then performs claim follow-up tasks (step 398). In one embodiment, as part of the claims follow-up tasks, the workflow processing engine 56 transmits a claim edit screen to the medical practice client 10 to enable the medical care provider to correct the claims that have errors. An exemplary claim edit screen 768 is illustrated in FIG. 7D and is described in more detail below. In another embodiment, the claim edit screen includes an explanation portion to explain the claim errors to the medical care provider. An exemplary explanation portion 770 of the claim edit screen 768 is illustrated in FIG. 7E. The medical care provider updates the claim based on the errors denoted in the claim review screen 756 and/or the explanation portion 770 of the claim edit screen 768. In one embodiment, the rules engine 60 scrubs the claim again following the editing by the medical care provider and the workflow processing engine 56 assigns a DROP status to the claim if no errors are found.” See, FIG. 7D-7E and ¶¶ [0094].

Appellant respectfully contends that the above passages show that one skilled in the relevant art would understand what is intended by Appellant’s claim 1 and would understand how to carry it out. Specifically, the above passages show a rules database which stores new rules, updated rules, or both. (See, ¶¶ [0045] and [0050]). The above passages further show that the new rules, updated rules, or both are applied to the insurance claim to examine the claim for errors. (See, ¶¶ [0062], [0087] and [0094]).

Finally, the above passages provide support for showing errors in a claim review screen and allowing a medical care provider to correct an error in the claim through the claim edit screen. That is, the inventors provided a specific example in which the claim errors are identified through the new and/or updated rules and corrected by the medical care provider. (See, FIGS. 7C-7E, ¶¶ [0087], [0089], [0091], and [0094]). As a result, Appellant respectfully submits that the inventors explicitly described the subject matter of claims 1, 15, 20, 27, and 28 in the specification in a way that reasonably conveys to one skilled in the art that they had possession of the claimed subject matter at the time of the filing of the application.

The passages above provide support for Applicants' claimed element "interacting with the insurance claim to correct an error by applying a new rule, an updated rule, or both ..." as recited in claims 1, 15, 20, 27, and 28. Furthermore, the Federal Circuit has made it clear that even a lack of literal support alone is not enough to warrant a written description rejection under 35 U.S.C. § 112. For example, the Federal Circuit upheld a patent directed to gasoline formulations claiming various combinations of ranges of chemical properties, where the claimed ranges were not described in *ipsis verbis* in the specification. *Union Oil Co. of California v. Atlantic Richfield Co.*, 54 U.S.P.Q.2d 1227, 208 F.3d 989, 998-1000 (Fed. Cir. 2000). The Federal Circuit held that the specification of the patent at issue informed the skilled artisan how to arrive at the claimed ranges and that the specification therefore complied with the written description requirement of § 112, first paragraph. Like the patent in *Unocal*, Appellant's specification provides a

clear and explicit description that informs skilled artisans on how to create and apply new and updated rules to correct an error in an insurance claim and fully complies with § 112, first paragraph. (See, Appellant's figures 2A-2B and 7C-7E, and Appellant's specification, ¶¶ [0045 – 0060] and [0087 – 0094]).

For all of the foregoing reasons Appellant respectfully submits that the 35 U.S.C. § 112, first paragraph rejection is improper and request that the rejection be withdrawn.

**B. The Rejection of Claims 1-6, 13-16, 18-20, 24-28, and 30-33 under 35 U.S.C. 103(a)**

The Final Office Action rejected claims 1-6, 13-16, 18-20, 24-28, and 30-33 under 35 U.S.C. 103(a) as being unpatentable over Burks and Campbell for substantially the same reasons given in the previous Office Action dated September 10, 2007 (hereinafter “the previous Office Action”), and further in view of Holloway.

**Claims 1-6, 13-14, 20, 24-26, 28, 30-33**

According to the previous Office Action, Burks allegedly discloses limitations (a) through (d), (f), and (h) of Claim 1. The previous Office Action asserts Burks fails to disclose limitations (e) and (g) of Claim 1, but that it would have been obvious to one of ordinary skill in the art at the time the invention was made to modify the method of Burks to include the limitations (e) and (g) that are purportedly taught by Campbell. The Final Office Action asserts Burks further discloses limitation (i). The Final Office Action asserts Burks and Campbell fail to explicitly disclose the limitations (j) and (k) of Claim

1, but that it would have been obvious to one of ordinary skill in the art at the time the invention was made to modify the combined teachings of Burks and Campbell to include the limitations (j) and (k) with the motivations of providing “a cost effective automated data processing system” that will “detect and correct … [claims] … errors” by using “expert systems as applied to the field of medical claims analysis and decision-making mechanisms for analyzing and applying payments to … [...] … medical claims.” See p. 5 and 6 of the Final Office Action; see also p. 3 through 7 of the previous Office Action.

Specifically, the Final Office Action asserts Holloway teaches (j) automatically and repeatedly interacting with the insurance claim to correct an error by applying a new rule, an updated rule, or both received from the payor server and (k) automatically and repeatedly updating the one or more insurance rules in the insurance company rules database that apply to the payor server by applying the new rule, the updated rule, or both received from the payor server. See p. 5 of the Final Office Action.

In particular, the Final Office Action points to the Summary of the Invention in Holloway as support for step (j). The Summary of the Invention discloses the CodeReview product. A medical claims processor receives one or more claims from a physician or billing company. The user subsequently manually enters claim information to the CodeReview system, which executes rules to determine whether to reject or authorize payment for each code. Holloway, col. 3, ll. 16-67.

Regarding step (k), the Final Office Action indicates Holloway teaches that the process “is an ongoing process which can be updated as new methods of inappropriate

coding are discovered.” Col. 3, ll. 35-37. Additionally, the Final Office Action points to Holloway, where that patent mentions a history database that updates and refines the knowledge base interpreter and the knowledge base and monitors savings associated with the recommendation. Col. 4, ll. 67 – col. 5, ll. 3. Lastly, the Final Office Action points to Holloway’s disclosure that development of the system “may lead to the development of new rules and a growth and refinement of the knowledge base interpreter.” Col. 10, ll. 57-60.

*1. Holloway, in combination with Burks and Campbell, do not teach or suggest every limitation of Claim 1.*

Appellant submits that the rejection under § 103 is improper because Holloway in combination with Burks and Campbell do not teach or suggest the claimed steps of (j) automatically and repeatedly interacting with the insurance claim to correct an error by applying a new rule, an updated rule, or both received from the payor server, and (k) automatically and repeatedly updating the one or more insurance rules in the insurance company rules database that apply to the payor server by applying the new rule, the updated rule, or both received from the payor server.

Burks teaches creating error messages when a data record does not contain the proper type and sending the error message to a computer station so that the computer station is informed of the improper data. Col. 9, lines 46-52; col. 12, lines 56-67; col. 13, lines 1-30. Burks also teaches receiving data messages from a trading partner and then

generating error messages which are sent to the trading partner “to inform them of erroneously transmitted messages.” Col. 7, lines 20-34; col. 15, lines 19-24. As such, the error message is not being utilized to automatically update an insurance claim or an insurance rule, but is instead being used to send a message regarding an error back to the healthcare provider (i.e., the computer station) or the trading partner. This error message only informs the provider of an error. It does not update the claim or the insurance rule. Stated differently, this kind of message represents the problem Appellant’s invention was designed to solve. Accordingly, Burks does not teach automatically and repeatedly updating an insurance rule or an insurance claim, but teaches notifying the computer station or the trading partner about an error.

Campbell teaches a “system for tracking workflow through a medical facility . . . , managing medical exams of patients in the facility, and managing a treatment protocol[s] for the patients.” Col. 1, lines 51-53. Campbell teaches that the “computer is responsible for handling billing of clients” which includes receiving or confirming some form of payment from the client. Col. 7, lines 13-15; col. 21, lines 14-16. Campbell further teaches automatically adding service items completed during the visit to the client’s invoice when the doctor completes the service on the therapy screen. Col. 15, lines 47-51. However, Campbell does not receive any information from a third party (i.e., a payor server) which is utilized to update an insurance claim and/or one or more insurance rules. Rather, “[t]he server removes the diagnosis from the rule out list, adds it to the tentative diagnosis, and determines which abnormal observations are linked to the diagnosis.”

Col. 17, lines 11-13. As such, the addition of service items and the movement of a diagnosis from the rule out list to the tentative diagnosis are not automatically and repeatedly occurring, but are based on actions by the doctor (i.e., doctor selects a diagnosis, provider team selects a service). Col. 18, lines 28-32.

Additionally, the rule out list in Campbell is a “list generated by the system . . . to select tentative diagnosis” of a patient and not rules for creating and updating an insurance claim. (Campbell et al.: col. 2, lines 25-27; col. 16, lines 66-67). Accordingly, Campbell teaches adding a service item based on a service and moving a diagnosis from one list to another list, and does not teach automatically and repeatedly updating an insurance claim based on insurance rule updates as claimed by Appellant.

Holloway also fails to teach or suggest both automatically and repeatedly interacting with an insurance claim to correct an error by applying a rule received from the payor server and automatically and repeatedly updating insurance rules that apply to the payor server by applying rules received from the payor server. Holloway discloses a cost effective automated data processing system for paying only appropriately coded claim amounts. See col. 3, ll. 6-9. A set of decision-making rules are used to assist the medical claims processor. While Holloway discloses that there is a need to “detect and correct” errors (See col. 2, ll. 14-16), Holloway does not teach or suggest *correcting an error in the insurance claim* as claimed in the present application. Rather, Holloway only determines whether to pay the submitted medical claim or claims; the “error corrected” is

preventing an incorrect payment, not correcting an error in the insurance claim. See col. 2, ll. 5-16; and col. 3, ll. 63-68.

Furthermore, Holloway does not teach or suggest *automatically and repeatedly* interacting with the *insurance claim*. Rather, Holloway discloses that a *user* must enter various facts from the claims into the computer system, and the system runs the rules *against a knowledge base*, not the insurance claim itself. See col. 3, ll. 25-37; col. 4, ll. 27-28 and ll. 51-64. “The interpreter 5, using the rules of the present invention, interacts with the knowledge base 6 of the present invention ...” See col. 4, ll. 56-58. Additionally, if the user did not enter sufficient information, the system prompts *the user* for additional information. See col. 4, ll. 60-62.

Holloway does not teach or suggest *automatically and repeatedly updating the one or more insurance rules* in the insurance company rules database *that apply to the payor server* by applying a new or updated rule *received from the payor server*. As indicated in the Final Office Action, Holloway merely discloses a history database (i.e., the HISTORY database) which (1) updates and refines the knowledge base interpreter and the knowledge base and (2) to monitors savings associated with the recommendation. Col. 4, ll. 68 - col. 5, ll. 3. The PROCESS database (which stores the user entered information) is appended to the HISTORY database “for recordkeeping purposes and for future use as a means to study these ‘case histories’ and refine, update, and change the rules and the knowledge base interpreter 5.” Col. 10, ll. 3-7. At best, Holloway teaches storing historical data that must be subsequently examined at a later time.

Additionally, Holloway fails to teach or suggest that the new rule, updated rule, or both are received from a payor server and stored in a set of insurance rules that apply to the payor server. Rather, Holloway discloses a single CodeReview product that interacts with one entity. Holloway, col. 4, ll. 25-27. The CodeReview product has a knowledge base of facts and a knowledge base interpreter which stores the rules and applies the knowledge base using the rules. Holloway, col. 3, ll. 30-35. Holloway does not teach how the rules are refined and or updated. Holloway fails to disclose any more than a third party which studies the case histories from the history database at a later point in time to manually effectuate new or updated rules. Col. 10, ll. 3-7. Thus, there is only one collection of rules, all the rules apply to the user of the CodeReview product, and the new or updated rules are not received from a payor server.

***2. The Examiner's combination of Holloway in combination with Burks and Campbell is improper because the combination does not yield claim 1 as a predictable result.***

The combination of Holloway, Burks and Campbell does not yield the claimed invention because the functions, when combined, do not yield Claim 1. One rationale to support a conclusion that the claim would have been obvious is that all the claimed elements were known in the prior art and one skilled in the art could have combined the elements as claimed by known methods with no change in their respective functions, and the combination yielded nothing more than predictable results to one of ordinary skill in

the art. *KSR International Co. v. Teleflex Inc. (KSR)*, 550 U.S. at \_\_\_, \_\_\_, 82 USPQ2d 1385, 1395 (2007). Therefore, when considering obviousness of a combination of known elements, the operative question is thus “whether the improvement is more than the predictable use of prior art elements according to their established functions.” *Id.* at \_\_\_, 82 USPQ2d at 1396.

The Final Office Action’s combination does not yield a predictable result because Holloway’s system and method for preventing payment of incorrect insurance claim payments, combined with Burks’ healthcare communication system, and combined with Campbell’s system for tracking workflow through a medical facility and managing medical exams and treatment protocols does not perform the following functions of

Claim 1:

(j) automatically and repeatedly interacting with the insurance claim to correct an error by applying a new rule, an updated rule, or both received from the payor server; and (k) automatically and repeatedly updating the one or more insurance rules, in the insurance company rules database, that apply to the payor server by applying the new rule, the updated rule, or both received from the payor server.

First, Holloway lacks any teaching or suggestion that the system for preventing payment of an incorrect insurance claim automatically and repeatedly interacts with an insurance claim by applying rules to correct an error with the insurance claim. Rather, Holloway is merely aimed at preventing incorrect payment of insurance claims on the payor side; claim errors are not corrected with application of rules, and all examination is performed by the system on data *extracted* from the submitted insurance claim (by the user of the system, i.e., a claims processor) *after* the insurance claim is submitted by the

requesting party. Second, as described above, Holloway lacks any teaching or suggestion that a payor server can automatically and repeatedly update the one or more insurance rules, in the insurance company rules database, that apply to the payor server.

Neither Burks nor Campbell cure the deficiency. As already stated above, Burks does not teach automatically and repeatedly updating an insurance rule or an insurance claim, but instead teaches notifying the computer station or the trading partner about an error. Campbell does not receive any information from a third party (i.e., a payor server) which is utilized to update an insurance claim and/or one or more insurance rules, so the addition of service items and the movement of a diagnosis from the rule out list to the tentative diagnosis are not automatically and repeatedly occurring, but are based on actions by the doctor. Thus, Campbell does not teach automatically and repeatedly updating an insurance claim based on insurance rule updates, but instead teaches adding a service item based on a service and moving a diagnosis from one list to another list.

Moreover, the Final Office Action's combination does not yield a predictable result because one skilled in the art could not have combined the elements, by known methods, to produce claim 1 without changing the elements' respective functions. Even if Holloway, Burks and Campbell were combined, the system would fail to achieve both correcting errors in a claim before submission to the insurance company and updating the one or more insurance rules by applying new or updated rules from the payor server (e.g., the insurance company). These differences are consistent with Appellant's purpose, which is to prevent the back-and-forth process of insurance claim settlement between the

payor and payee. Thus, one skilled in the art would face extensive and undue experimentation in attempting to transform Holloway's "erroneous-payment" prevention system into the claimed system for continuously and automatically interacting with an insurance claim before its submission to the payor to avoid lengthy, and ultimately costly delays in insurance claim processing.

***3. The combination of Holloway with Burks and Campbell is improper because, taken as a whole, there is no teaching, suggestion, or motivation to combine the references.***

Again, Holloway, Burks and Campbell do not teach all of the steps claimed by Appellant. However, even if a combination of Holloway with Burks and Campbell taught or suggested every element of claim 1 and the elements in combination performed the function that each element performed separately, a rejection under 35 U.S.C. § 103(a) would still be improper because Holloway does not provide any teaching or suggestion to combine with, or modify according to, Burks and/or Campbell.

Burks discloses a system with two main components: (1) a medical transaction system and (2) a generic transaction database. (Burks, FIGS. 1-3, col. 7, ll. 6-18; ll. 35-40) The medical transaction system itself is subdivided into two major elements: (a) the communications layer components (i.e., the transaction manager receiver and portions of the service routine) and (b) the medical transaction processing kernel (i.e., the remaining portions of the service routine, the disc scanner, compiler, verifier, response generator,

and financial transactor). (Burks, col. 9, ll. 10-21) Burks teaches away from a system that requires a centralized database for validating and formatting an electronic medical claim that must be maintained with insurance carrier data. Col. 2, ll. 3-6. Rather, the generic transaction database stores a history of the messages received which can later be used to provide statistical use of the system. (Col. 7, ll. 35-55) As discussed above, Burks does not disclose modifying rules or an insurance claim, but merely notifying the computer station or the trading partner about an error. The motivation of Burks is to provide a medical transaction computer system capable of integrating the functions of obtaining medical data records with the function of medical healthcare claim processing while (1) not using a particular communication protocol, (2) not validating and processing all the data messages received from the computer stations at a central processing station, and (3) not transmitting medical claims to insurance carriers in the same communication format and protocol used by the computer stations at the insurance carriers.

Campbell teaches a system for tracking workflow through a medical facility and managing medical exams and treatment protocols for patients. Col. 1, lines 51-53. The system disclosed in Campbell includes a server computer in communication with a number of personal computers, where the server computer manages access to server functions and data. Campbell, FIG. 2, col. 5, ll. 33 – 38; col. 6, ll. 25-27. The server computer is connected to a central computer that acts as the central computer for several hospitals, controlling administrative and billing functions. Campbell, col. 7, ll. 1-15. As

discussed above, Campbell only discloses automatically adding service items completed during the visit, not correcting an error in response to running a rule and repeatedly interacting with the insurance claim.

Holloway discloses a system residing on the claim processor side including a user interface computer system that receives input from a user *based on* the claims. The claim has already been completed and submitted upon receipt by the user. The user interface computer system is in communication with a knowledge base interpreter and knowledge base, as discussed above, to run rules against the user-provided information. Also as discussed above, a history database stores historical information, which can later be reviewed by a third party to update the knowledge base interpreter and knowledge base. Holloway, FIG. 1, col. 3, ll. 6-9; col. 4, ll. 23 – col. 5, ll. 3; col. 10, ll. 3-7.

Appellant respectfully submits that one of ordinary skill in the art would not be motivated to modify the disclosure of Holloway by the disclosure of Burks or Campbell because Holloway's "improper-payment" prevention system in no way benefits facilitating payor and financial institution communication as disclosed by Burks or managing exams, diagnoses, and treatment protocols as disclosed by Campbell. "[T]here must be some articulated reasoning with some rational underpinning to support the legal conclusion of obviousness." *KSR Int'l Co. v. Teleflex Inc.* 550 US \_\_\_\_ (2007) (quoting *In re Kahn*, 441 F. 3d 977, 988, 78 USPQ2d 1329, 1336 (Fed. Cir. 2006)). Moreover, there is no motivation to combine Burks, Campbell, or Holloway because they differ in the nature of the problem to be solved (e.g., facilitating communication while *not*

requiring a centralized database or common communication protocol, managing exams and treatments within the health care practice, and preventing erroneous insurance claim payments on the payee, respectively, as opposed to reducing the administrative costs for filing and processing health insurance claims as in the Appellant's invention).

Further, the disclosed systems and methods of Burks, Campbell, and Holloway are too dissimilar to provide a motivation to combine the references. Burks clearly teaches away from a centralized database with information from each insurance carrier (i.e., the insurance company rules database of Appellant's invention). However, Campbell requires a server computer which controls access to a centralized database that contains information from the connected personal computers. Not only does Campbell require a centralized database, but Burks merely notifies a transmitting computer of an error, and Campbell still fails to correct an error on the client side. Third, the system of Holloway operates entirely on the claims processor side, which does not address error correction on the client side. Additionally, Holloway merely applies the rules and rejects the claim if an error is detected, leaving it up to the client to determine why payment was rejected and to start the process all over again with a corrected insurance claim.

A prior art reference must be considered in its entirety, i.e., as a whole, including portions that would lead away from the claimed invention. *W.L. Gore & Associates, Inc. v. Garlock, Inc.*, 721 F.2d 1540, 220 USPQ 303 (Fed. Cir. 1983), cert. denied, 469 U.S. 851 (1984). In this case, where Holloway discloses preventing erroneous payment of potentially fraudulent insurance claims on the payor side, but not interaction with the

insurance claim and the submitting party to verify the accuracy of the claim and to correct errors. Burks discloses eliminating both a communication protocol and a centralized database for validating and formatting an electronic medical claim. Campbell teaches managing workflow, medical exams, and treatments all within the medical facility. None of the references disclose automatically and repeatedly interacting with insurance claims to correct errors or updating insurance rules. Thus, the cited art, taken as a whole, not only fails to teach or suggest the desirability of Appellant's claimed invention, but also fails to lead to the claimed combination at all.

As claims 2-6, 13-14, and 24-26 depend from 1, and contain all of the limitations recited therein, it is believed that they are patentable over the prior art of record for similar reasons. Independent claim 20 includes similar limitations to allowable claim 1, and is believed to be patentable over the prior art of record for similar reasons. As claims 30-33 depend from allowable claim 28, and contain all of the limitations recited therein, it is believed that they too are patentable over the prior art of record for similar reasons.

#### **Claims 15-16, 18-19**

Independent claim 15 includes similar limitations to allowable claim 1 as discussed above, and is believed to be patentable over the prior art of record for similar reasons. As claims 16 and 18-19 depend from allowable claim 15, and contain all of the

limitations recited therein, it is believed that they are patentable over the prior art of record for similar reasons.

### **Claim 27**

Independent claim 27 includes similar limitations to allowable claim 1 as discussed above, and is believed to be patentable over the prior art of record for similar reasons.

### **C. The Rejection of Claims 9-11 under 35 U.S.C. 103(a)**

The Final Office Action rejected claims 9-11 under 35 U.S.C. § 103(a) as being unpatentable over Burks and Campbell and Holloway as applied to claims 1 and 2, and further in view of Berman for substantially the same reasons given in the previous Office Action (paper number 20070829).

Claims 9-11 recite a method dependent from claim 1. Claim 1 teaches a method for managing a medical practice.

As stated above and as previously stated in Appellant's response to the previous Office Action, Burks, Campbell, Berman, and Holloway, fail, at least, to teach a method (as embodied in independent claim 1) that (i) submits the insurance claim to the payor server, (j) automatically and repeatedly interacts with the insurance claim to correct an error by applying a new rule, an updated rule, or both received from the payor server, and

(k) automatically and repeatedly updates the one or more insurance rules, in the insurance company rules database, that apply to the payor server by applying the new rule, the updated rule, or both received from the payor server. Therefore, the combination of Burks, Campbell, Berman, and Holloway does not render the claims 9-11 unpatentable.

Applicant reiterates the discussion of Burks, Campbell, and Holloway recited above. Thus, the discussion of these references does not need to be repeated herein.

Berman teaches an email-based system wherein personnel at the client site compose service requests and email them directly to the sponsors, upon which sponsors then receive the email messages in an email inbox, perform the request manually, and then send a response email. Col. 3, lines 44-52. Berman fails to disclose the limitations as discussed above with reference to claim 1, namely, steps (i) through (k).

Thus, Burke, Campbell, Berman, and Holloway fail to teach or suggest numerous aspects of the invention, as embodied in independent claim 1. For at least these reasons, the rejections for claims 9-11 as now amended should be withdrawn and the claims passed to allowance by virtue of their dependency from claim 1 as now amended, their distinctions from the prior art of record, and the additional features recited therein.

**C. The Rejection of Claim 12 under 35 U.S.C. 103(a)**

The Final Office Action rejected claim 12 under 35 U.S.C. § 103(a) as being unpatentable over Burks and Campbell and Holloway as applied to claims 1 and 2, and further in view of Ilsen for substantially the same reasons given in the previous Office Action (paper number 20070829).

Claim 12 recites a method dependent from claim 1 wherein the workflow tasks in the patient workflow performed during the event further comprise at least one of performing check-in tasks, performing check-out tasks, or any combination thereof. Claim 1 teaches a method for managing a medical practice.

As stated above and as previously stated in Appellant's response to the previous Office Action, Burks, Campbell, Berman, and Holloway, fail, at least, to teach a method (as embodied in independent claim 1) that (i) submits the insurance claim to the payor server, (j) automatically and repeatedly interacts with the insurance claim to correct an error by applying a new rule, an updated rule, or both received from the payor server, and (k) automatically and repeatedly updates the one or more insurance rules, in the insurance company rules database, that apply to the payor server by applying the new rule, the updated rule, or both received from the payor server. Therefore, the combination of Burks, Campbell, Berman, and Holloway does not render claim 12 unpatentable.

Applicant reiterates the discussion of Burks, Campbell, and Holloway recited above. Thus, the discussion of these references does not need to be repeated herein.

Ilsen teaches a “system, [which] provides an automated service to patients, through which access to their own doctor is provided over the Internet without additional work for the doctor’s office because it is based upon existing records.” Col. 4, lines 24-29. Furthermore, Ilsen teaches that the system provides information “for simply inquiries and follow-up instructions, for prescription refill and appointment requests, and for directions to the office, laboratory, radiologist or specialist’s office, general information and the like.” Col. 9, lines 33-37. Ilsen fails to disclose the limitations as discussed above with reference to claim 1, namely, steps (i) through (k).

Thus, Burks, Campbell, Berman, and Holloway fail to teach or suggest numerous aspects of the invention, as embodied in independent claim 1. For at least these reasons, the rejection for claim 12 should be withdrawn and the claims passed to allowance by virtue of its dependency from claim 1 as now amended, its distinctions from the prior art of record, and the additional features recited therein.

### **VIII. CLAIMS APPENDIX**

The following listing presents the claims as currently appealed:

Claim 1        A method for managing a medical practice comprising:

- (a) storing one or more insurance rules in an insurance company rules database on a medical practice management server;
- (b) communicating with a medical practice client user interface over a first communication network;
- (c) communicating with a payor server over a second communications network;
- (d) receiving information associated with an event related to a patient from at least one of the medical practice client user interface or the payor server;
- (e) performing, by the medical practice management server, one or more workflow tasks in a patient workflow associated with the event;
- (f) performing, by the medical practice management server, one or more workflow tasks in a billing workflow, which creates, examines, and processes an insurance claim, associated with the event;
- (g) automatically and repeatedly interacting with the information associated with the event during the patient workflow tasks and billing workflow tasks to correct an error, a deficiency, or any combination thereof by applying one or more rules within a set of rules in a rules engine;

- (h) using at least a portion of the information, which is defined by one or more insurance rules in the insurance company rules database that apply to the payor server, associated with the event and used to create the insurance claim, which is formatted according to the one or more insurance rules that apply to the payor server, following completion of the one or more tasks;
- (i) submitting the insurance claim to the payor server;
- (j) automatically and repeatedly interacting with the insurance claim to correct an error by applying a new rule, an updated rule, or both received from the payor server; and
- (k) automatically and repeatedly updating the one or more insurance rules in the insurance company rules database that apply to the payor server by applying the new rule, the updated rule, or both received from the payor server.

Claim 2        The method of claim 1 further comprising verifying the information at least one of before, during, or following performing the workflow tasks in the patient workflow associated with the event, or any combination thereof.

Claim 3        The method of claim 1 further comprising the steps of:

- (l) receiving an error notification; and
- (m) performing a correcting action in response thereto.

Claim 4        The method of claim 3 wherein the performing the correcting action further comprises transmitting an error message denoting an error to the medical practice.

Claim 5        The method of claim 3 wherein the correcting action comprises correcting at least one of a typographical error, a formatting error, incomplete information, or any combination thereof.

Claim 6        The method of claim 3 further comprising generating the error notification.

Claims 7-8    (Cancelled)

Claim 9        The method of claim 2 wherein the performing of the workflow tasks in the patent workflow before the event further comprises the steps of at least one of receiving a request for an appointment, searching for the patient in a patient information database, receiving insurance information; receiving referral information, receiving a proposed schedule appointment, or any combination thereof.

Claim 10 The method of claim 9 wherein the receiving insurance information further comprises the steps of parsing the insurance information and determining whether the patient is eligible.

Claim 11 The method of claim 9 wherein the receiving referral information further comprises defining a referral rule category, an appointment type class, and an intersection of the referral rule category and the appointment type class.

Claim 12 The method of claim 2 wherein the workflow tasks in the patient workflow performed during the event further comprise at least one of performing check-in tasks, performing check-out tasks, or any combination thereof.

Claim 13 The method of claim 2 wherein the performing of the workflow tasks in the billing workflow following the event further comprise the steps of at least one of:  
receiving a claim,  
scrubbing the claim,  
assigning a status to the claim,  
submitting the claim to the payor server,  
triggering an alarm upon not receiving a response from the payor server,  
performing claim follow-up tasks,  
posting payments, or

any combination thereof.

Claim 14      The method of claim 1 wherein the transactions performed with the payor server further comprises at least one of

- claim submittals,
- claim receipt acknowledgements,
- claim status checks,
- patient eligibility determinations,
- authorization and referral requests and grants,
- remittance advice, or

any combination thereof.

Claim 15      A medical practice management system comprising:

- a medical practice client user interface for communicating with a medical practice;
- a payor server for communicating with a payor organization; and
- a medical practice management server computer in communication with the medical practice client user interface over a first communications network and the payor server over a second communications network to receive information associated with an event related to a patient from at least one of

the medical practice client user interface, the payor server, or any combination thereof,

the medical practice management server computer comprising  
an insurance company rules database storing one or more sets of rules, each  
set of rules comprises one or more insurance rules that apply to the payor  
server,

a workflow processing engine performing one or more patient workflow tasks  
and one or more billing workflow tasks, which creates, examines, and  
processes an insurance claim, associated with the event,

a rules engine in communication with the workflow processing engine for  
repeatedly and automatically interacting with the information associated  
with the event to correct an error, a deficiency, or any combination thereof  
by applying one or more rules in a set of rules to the information in  
connection with the performance of the one or more patient workflow  
tasks and one or more billing workflow tasks, and

an intelligent transactions relationship module in communication with the  
workflow processing engine and the payor server for submitting the  
insurance claim to the payor server,

automatically and repeatedly interacting with the insurance claim to correct an  
error by applying a new rule, an updated rule, or both received from the  
payor server, and

automatically and repeatedly updating one or more insurance rules in the insurance company rules database that apply to the payor server by applying the new rule, the updated rule, or both received from the payor server.

Claim 16 The medical practice management system of claim 15 further comprising a patient information database and an insurance information database.

Claim 17 (Cancelled)

Claim 18 The medical practice management system of claim 15 wherein the workflow processing engine further comprises a verifier to verify the information at least one of before, during, or following performing the patient workflow tasks associated with the event, or any combination thereof.

Claim 19 The medical practice management system of claim 15 wherein the workflow processing engine communicates with a central billing office to generate and submit a claim to the payor server.

Claim 20 A medical practice management system comprising:

- (a) means for storing one or more insurance rules in an insurance company rules database on the medical practice management system;
- (b) means for communicating with a medical practice user interface over a first communications network;
- (c) means for communicating with a payor server over a second communications network;
- (d) means for receiving information associated with an event related to a patient from at least one of the medical practice client user interface or the payor server;
- (e) means for performing one or more patient workflow tasks associated with the event;
- (f) means for performing one or more billing workflow tasks, which creates, examines, and processes an insurance claim, associated with the event;
- (g) means for automatically and repeatedly interacting with the information associated with the event during the patient workflow tasks and billing workflow tasks to correct an error, a deficiency, or any combination thereof by applying one or more rules within a set of rules in a rules engine;
- (h) means for using at least a portion of the information, which is defined by the one or more insurance rules in the insurance company rules database that apply to the payor server, associated with the event and used to create the insurance claim, which is formatted according to the one or more insurance

rules that apply to the payor server, following completion of the one or more tasks;

- (i) means for submitting the insurance claim to the payor server;
- (j) means for automatically and repeatedly interacting with the insurance claim to correct an error by applying a new rule, an updated rule, or both received from the payor server; and
- (k) means for automatically and repeatedly updating one or more insurance rules in the insurance company rules database that apply to the payor server by applying the new rule, the updated rule, or both received from the payor server.

Claims 21-23 (Canceled)

Claim 24        The method of claim 1 wherein a portion of the information associated with the event comprises first procedure information and second procedure information.

Claim 25        The method of claim 2 wherein the performing of the workflow tasks in the billing workflow following the event further comprise the steps of moving the claim into a claim inquiry group and assigning an additional task to be completed to close the claim.

Claim 26 The method of claim 1 wherein the one or more rules in the set of rules have universal applicability, apply only to one or more specific insurance packages, apply only to specific medical care providers, or any combination thereof.

Claim 27 A method for managing a medical practice comprising:

- (a) storing one or more rules in an insurance company rules database;
- (b) communicating with a medical practice client user interface over a first communication network;
- (c) communicating with a payor server over a second communications network;
- (d) receiving information associated with an event related to a patient from at least one of the medical practice client user interface, the payor server, or any combination thereof;
- (e) performing one or more workflow tasks in a patient workflow associated with the event;
- (f) performing one or more workflow tasks in a billing workflow, which creates, examines, and processes an insurance claim, associated with the event;
- (g) after performance of the one or more workflow tasks in the patient workflow and the one or more workflow tasks in the billing workflow, storing at least a portion of the information associated with the event, which is defined and formatted by one or more rules in the insurance company rules database that

apply to the payor server, for a purpose other than to create the insurance claim;

- (h) automatically and repeatedly interacting with the information associated with the event in connection with the performed patient workflow and billing workflow tasks by applying one or more rules to correct an error, a deficiency, or any combination thereof;
- (i) submitting the insurance claim to the payor server;
- (j) automatically and repeatedly interacting with the insurance claim to correct an error by applying a new rule, an updated rule, or both received from the payor server; and
- (k) automatically and repeatedly updating the one or more insurance rules in the insurance company rules database that apply to the payor server by applying the new rule, the updated rule, or both received from the payor server.

Claim 28      A computer program product, tangibly embodied in an information carrier, for managing a medical practice management system, the computer program product including instructions being operable to cause a data processing apparatus to:

- (a) store one or more insurance rules in an insurance company rules database on the medical practice management system;
- (b) communicate with a medical practice client user interface over a first communication network;

- (c) communicate with a payor server over a second communications network;
- (d) receive information associated with an event related to a patient from at least one of the medical practice client user interface, the payor server, or any combination thereof;
- (e) perform one or more workflow tasks in a patient workflow associated with the event;
- (f) perform one or more workflow tasks in a billing workflow, which creates, examines, and processes an insurance claim, associated with the event;
- (g) automatically and repeatedly interact with the information associated with the event during the patient workflow tasks and billing workflow tasks to correct an error, a deficiency, or any combination thereof by applying one or more rules within a set of rules in a rules engine;
- (h) use at least a portion of the information, which is defined by one or more insurance rules in the insurance company rules database that apply to the payor server, associated with the event and used to create the insurance claim, which is formatted according to the one or more insurance rules that apply to the payor server, following completion of the one or more tasks;
- (i) submit the insurance claim to the payor server;
- (j) automatically and repeatedly interact with the insurance claim to correct an error by applying a new rule, an updated rule, or both received from the payor server; and

(k) automatically and repeatedly update one or more insurance rules in the insurance company rules database that apply to the payor server by applying the new rule, the updated rule, or both received from the payor server.

Claim 29 (Canceled)

Claim 30 The computer program product of claim 28 further comprising instructions being operable to cause the data processing apparatus to verify the information at least one of before, during, or following performing the workflow tasks in the patient workflow associated with the event, or any combination thereof.

Claim 31 The computer program product of claim 28 further comprising instructions being operable to cause the data processing apparatus to:

- (l) receive an error notification; and
- (m) perform a correcting action in response thereto.

Claim 32 The computer program product of claim 31 wherein performing the correcting action further comprises causing the data processing apparatus to transmit an error message denoting an error to the medical practice.

Claim 33      The computer program product of claim 31 wherein the correcting action comprises causing the data processing apparatus to correct at least one of a typographical error, a formatting error, incomplete information, or any combination thereof.

**IX. EVIDENCE APPENDIX**

None.

**X. RELATED PROCEEDINGS APPENDIX**

None.

**XI. CONCLUSION**

For the reasons stated above, it is requested that the Examiner's rejection of all pending claims under 35 U.S.C. § 112, first paragraph and 35 U.S.C. § 103(a) be reversed.

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